ADHS/DBHS Clinical and Recovery Practice Protocol

Peer Workers/Recovery Support Specialists within Behavioral Health Agencies

Developed by the
Arizona Department of Health Services
Division of Behavioral Health Services

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Title
Peer Workers/Recovery Support Specialists within Behavioral Health Agencies

Goal/What Do We Want to Achieve Through the Use of this Protocol?
To provide guidance to Behavioral Health Agencies in implementing peer worker/recovery support services within their organizations and to enhance the effectiveness of mental health and substance use disorder services through the expansion of peer-delivered services.

Target Population(s)
The Peer Worker/Recovery Support Specialist Practice Protocol is targeted to all adult agencies and organizations that hire individuals who are or have been service recipients of the behavioral health system. Targeted employees include individuals that are or have been enrolled in behavioral health programs, such as general mental health, substance abuse and serious mental illness services.

Definitions

- **Behavioral Health Paraprofessional**: means an individual who meets the applicable requirements in R9-20-204 and has:
    a. An associate's degree;
    b. A high school diploma; or
    c. A high school equivalency diploma.

- **Recovery:** Recovery is a deeply personal process and no single, universally accepted definition of recovery currently exists. In the simplest sense, recovery is a *lived experience* of moving through and beyond the limits of one's disorder. In the process, individuals develop a positive and meaningful sense of identity separate from their condition, disability or its consequences in their life.[1] Key characteristics of recovery include:

    - Recovery is personal and individualized (not defined by a treatment agency)
    - Recovery moves beyond symptom reduction and relief (e.g. meaningful connections in the community, overcoming specific skill deficits, establishing a sense of quality and well-being)
    - Recovery is both a process of healing (regaining) and a process of discovery (moving beyond)
    - Recovery encompasses the possibility for individuals to test, make mistakes and try again.

    Recovery can occur within or outside the context of professionally directed treatment, and where professional treatment is involved, it may, depending on its orientation and methods, play a facilitative, insignificant or inhibiting role in the recovery process.[2] A small yet exciting body of research suggests that peer-delivered services produce outcomes superior to professional treatment alone in several key domains, including increased social networks, lower levels of worry and improved satisfaction with life.[3]

    Peer-Delivered Services: Peer-delivered services reflect a continuum of programs and supports provided by individuals who identify themselves as having behavioral health challenges and are receiving or have received behavioral health care. Peer services can include programs that are peer-operated (planned,

[1] White. W., M. Boyle and D. Loveland. "Recovery from Addiction and Mental Illness: Shared and Contrasting Lessons" in: Recovery in Mental Illness: Broadening Our Understanding of Wellness. 2005. (in press).
[2] Ibid.
[3] Solomon, P. "Peer Support/Peer Provided Services: Underlying Processes, Benefits and Critical Ingredients." Psychiatric Rehabilitation Journal. 27(4). 2004.

delivered and administered by people with lived experience), peer partnerships (shared governance between peer and non-peer organizations or staff) and peer employees – the unique discipline of providing peer services as a member of the target population.

- **Peer/Recovery Support:** Social and emotional support, generally coupled with specific, skill-based training, coaching or assistance, that is provided to bring about a targeted social or personal change at the symptom, individual, family or community level. Targets for peer support services can include a variety of individualized and personal goals, including living preferences, employment or educational goals and development of social networks and interests.

- **Peer Worker:** Peer Worker refers to an individual who is, or has been, a recipient of behavioral services and who currently provides behavioral health services to individuals enrolled in the public behavioral health system. The peer worker may be either an employee or volunteer/unpaid. Services that may be provided by a peer worker vary depending on the peer worker's education and experience. For example, a peer worker who is also behavioral health professional can provide all of the treatment and support services that the agency is able to provide under the agency's OBHL license or the agency's ADHS/DBHS Community Services Agencies Title XIX certification. Peer Workers may have job titles such as Peer Support Specialists, Recovery Guides, Recovery Specialists, etc.

Background

A growing body of scientific evidence and the personal, real-life experiences of individuals in recovery from addiction and mental illnesses support development of the role of "peer workers" as a unique discipline within the behavioral health workforce. Looking to a "peer" for assistance in achieving a goal is neither new nor exclusive to behavioral health services. The advancement of individuals, nations and societies has fundamentally been grounded in using the first-hand knowledge of others to move forward. A few simple examples include:

- A woman with her first child seeks counsel from her mother and/or other mothers on the basics of child rearing.
- The Little League baseball coach teaches a young player the fundamentals of how to bunt, run bases, or throw a curve ball.
- Business ventures hire expert consultants to help them grow and stay successful.

The common thread in these and a thousand other examples of "peer assistance" or "peer support" is tapping the counsel/wisdom of others "who have been there" to achieve a desired or positive outcome. In working with individuals with behavioral health disorders, the dimension added through peer support services is a sense of empowerment and hope. This experience has roots in science as well as the self-reported outcomes of individuals who both deliver -- and receive -- peer services. Key theoretical constructs underlying peer/recovery support services include:

- *Social Support Theory* – The presence of supportive relationships that contribute to positive adjustment and assist individuals in weathering stress and adversity;
- *Experiential Knowledge* – Validation and increased confidence arising from interactions with individuals with similar backgrounds, experiences and challenges;
- *Social Learning Theory* – Availability of credible role models as "teachers," "consultants" or "coaches."

A mix of rigorous and observational studies are contributing to the science base for developing a peer workforce within behavioral health agencies, including evidence of positive outcomes at the individual (increased confidence, competence and self-efficacy), agency (improved employment outcomes, reduced

inpatient utilization, increased satisfaction among service recipients and staff) and system level (reduced stigma, improved engagement and no-shows for appointments).[4]

While science may only now be racing to catch up, both the mental health and addictions fields have rich, long-standing histories of peer-based recovery efforts. Native American "recovery circles" were active in the U.S. as early as the 1760s. These early "mutual aid associations" fused a re-discovery of the unique power of a cultural community with an individual's desire to stop drinking. Mutual Aid Societies were common throughout the U.S. during the 1800s and early 1900s. The Washingtonians, Fraternal Temperance Societies, Alcoholics Anonymous, Secular Organization for Sobriety, Wellbriety, and Faith-based Recovery Ministries are only a few of the organizations that have emerged based on the strengths and commitment to serve others by individuals with first-hand recovery wisdom and knowledge.

The mental health arena traces its earliest "peer-delivered services" to the work of Clifford Beers, a gentleman who, upon his release from a state psychiatric hospital, launched an advocacy movement that evolved into what is known today as the National Mental Health Association. More recently, the mental health community has embraced a "recovery model" for severe mental illnesses, sparked by Boston University pioneer William Anthony's call for the 1990s to be known as "the decade of recovery." The enduring value of peers helping peers in recovery is seen today in a variety of mutual assistance and advocacy organizations, including the National Alliance of Psychiatric Survivors, the National Mental Health Consumers Association, the European Client Unions Network, and the World Federation of Psychiatric Users. From a few fledging "self-help" groups in the days of "Bill W. and Dr. Bob," as of November 2001, worldwide membership of Alcoholics Anonymous was estimated to be two million or more, with nearly 100,800 groups meeting in approximately 150 countries around the world (Alcoholics Anonymous, 2001).

Historically, peer-based recovery services evolved when formal behavioral health and social welfare systems failed to meet the full spectrum of individual and family needs in recovery. Today peer-delivered supports are viewed as complimenting counseling and other medical interventions by adding the dimension of hope imparted by "one who has been there." In addition, employment of peer workers within traditional treatment environments garners clear benefits to both the peer provider and the organization as a whole in terms of enhanced confidence and self-efficacy, reduced utilization of higher-cost services and eliminating stigma within the workplace. The powerful combination of non-peer and peer-delivered service increases the possibility for people receiving services to develop a functional recovery lifestyle, to overcome or live beyond their behavioral health condition, and to contribute in powerful and meaningful ways to family, community and society.

The following comments from the peer workforce in Arizona illustrate the benefits of employing persons receiving services and former service recipients to deliver support services within behavioral health agencies[5]:

> "Working with peers is extremely encouraging and rewarding."
>
> "A person's utilization of mental health services does not negate their intelligence, skills, talents or personal strengths."
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> "Research has found that peers, on average, take fewer sick days than other employees and the time they do take off is more often related to issues other than mental health symptoms."

[4] Ibid.
[5] Informal survey of the peer workforce, fall 2005. Recovery Empowerment Network, META, Native American Connections, HOPE, Inc.

"Some may worry if peers are "stable" enough to return to work. Peers, when considering employment, take action to develop tools and skills to maintain their recovery. Research has found that work is more likely to reduce the frequency, duration, and intensity of behavioral health symptoms rather than to increase them."

"Because of the effort individuals put forth to overcome their symptoms, they enter the workforce fully committed to their jobs and are usually more receptive to constructive feedback to improve their work performance."

"Peers who choose employment in the behavioral health field have qualifications that persons who have not experienced mental illness or addiction do not. They can share hope and encouragement and often alleviate the fears and uncertainty of the people they serve because they "have been there."

"The role of a supervisor/manager is to acknowledge each person's unique contribution to the team. In this situation, any labels, such as "peer," quickly become irrelevant."

Recommended Process/Procedures

I. Identifying the Role of the Peer/Recovery Specialist

In Arizona, the minimum staffing requirement for peer-delivered services within licensed behavioral health agencies is the behavioral health paraprofessional. Peer workers that meet the requirement to function as a paraprofessional may work in any role for which they are qualified within the organization. In addition, peer employees hired by a certified Community Service Agency (CSA) must also meet minimum staffing requirements for paraprofessionals within licensed behavioral health agencies as defined in R9-20-101 and R9-20-204 to deliver supportive services identified on a treatment plan.

The workplace role of the peer/recovery worker in a behavioral health agency is flexible and varied. The constant among all roles a peer/recovery worker may perform is that the peer provider is the embodiment of recovery. For staff that have only seen clients at their worst – in a crisis situation, when their symptoms are flaring or following their most recent substance relapse -- it is illuminating and rewarding to work closely with someone who has lived with behavioral health challenges yet can contribute to a rich service team.

Peer/recovery specialists may work alongside treatment staff such as counselors, physicians and nurses, in a clinic setting or in the home or community. Peer providers offer a unique mechanism for serving individuals in need of behavioral health treatment who are alienated from the system, have had negative experiences with formal treatment, or require consistent engagement and support to seek services for mental illness or addiction issues. Common roles for peer employees in agency settings include providing education "about treatment," engaging family and friends in building an Adult Clinical/Recovery Team and linking the individual to natural supports including education on locating and using recovery resources within the community. Some peer/recovery specialists work independently, visiting people in their homes or at other locations in the community. Peers may also provide a range of specific educational and coaching services, including Wellness Recovery Actions Plans (WRAP) and Wellness Planning, skills training, preparation for GED or other career paths, work supports and job/role modeling and even training to work as a peer/recovery specialist. Agencies with a unique cultural orientation to behavioral health treatment have successfully used peer employees to assist individuals in re-discovering their culture and heritage as a means of building recovery capital within their lives.

In addition to providing services in agencies licensed or certified by the ADHS Office of Behavioral Health Licensure (e.g. outpatient clinics, residential agencies, inpatient treatment programs) many employment opportunities exist in peer or consumer-operated programs (e.g. recovery centers/drop-in programs) certified as a CSA. Peer-run programs often have the same goals as traditional programs including:

- Providing services to assist and support individuals in their housing, employment and education;
- Crisis respite services;
- Warm Lines;
- Educational groups and classes;
- Support and crisis diversion in collaboration with the clinical team;
- Social/recreational/civic activities; and
- Transportation.

II. Agency Preparation and Key Components of a Successful Peer Program

Behavioral Health Agencies seeking to develop a peer workforce should invest sufficient time and attention to planning early in the process. While some agencies may consider electing a "just do it approach" to hiring peers in their agency, it is highly recommended that a period of planning and infrastructure development occur to help ensure the success of the peer program. Key decision points can include strategies for recruiting, hiring and integrating peer workers within the agency workforce, ensuring current human resources policies are flexible enough to accommodate a peer workforce, supervisor training, considering change in the organizational climate that will emerge through the presence of a peer workforce and developing structures and processes in advance to deal with issues such as roles/boundaries, professionalism and wellness.

Key components of a successful program include:

Leadership
Management buy-in to implementing a peer support program is critical. While the agency CEO or board president may serve as the vocal champion of the peer/recovery workforce, the agency leadership team should designate an upper-management point person with responsibility for operational aspects of the peer employment program. The point person will work closely with human resource staff, training units, clinical directors and program administrators to ensure the smooth integration of the peer workforce into the agency, including trouble-shooting professional relationships between peer and clinical staff.

The Agency Environment
Understanding how a recovery orientation fits within the organization and identifying the specific values and beliefs of clinical staff is essential to developing an environment in which a peer workforce can thrive. Soliciting ideas and feedback from clinical staff regarding the potential roles and contribution of a peer workforce within the agency helps cement "buy-in" from staff and ensures a more seamless integration into the agency's service structure. Careful planning will also help prevent some obstacles to effective implementation, including any perceptions that peer workers are disconnected from the agency's "primary" or "real" services and lack of staff support.

Agencies undertaking an expansion to hire peer workers should take some time to re-assess their own organizational mission and values to ensure an organizational environment in which recovery – rather than the process of treatment — is viewed as the goal of participation in behavioral health services and the contribution of the peer workforce is valued as the embodiment of that recovery. Assessing an agency's values and recovery orientation can be undertaken through facilitated discussion groups, staff surveys, and other opportunities for training and dialogue that address questions such as:

- Does the organization have a concept/definition of recovery?
- Can people enter recovery on their own (e.g. natural recovery)? Is professional treatment always necessary?
- How does the organization view its role and service delivery fitting with the individual journey of recovery?

- Is recovery incremental or transformational? Is it a goal or a process? Both?
- What is the role of families in the organization?
- Does staff believe that an individual must "hit bottom" or experience "pain" or have they learned that hope (experiencing the possible) is one of the most powerful drivers of change?
- Are organizational policies and operating processes, such as admission and discharge standards and front office procedures aligned with one or the other?
- Does staff still believe that people need to be "committed" or "compliant" in order to benefit from services?
- How does spirit (spirituality) manifest itself in people in recovery?

As agencies implement a peer employee workforce, they may find it helpful to re-visit questions such as these at regular intervals. Do not be surprised if the answers change over time. A viable peer program in which workers participate side-by-side with clinical staff will transform the attitudes, beliefs and values of the organization.

Structure, Standards and Procedures

Advance planning on key structural and procedural needs of a peer employee program is highly recommended. Agencies should take the time to define the role or roles of peer employees within the work environment and clinic services, including offering a range of employment options (fulltime, part-time, temporary or unscheduled/as needed) and developing clear job descriptions and performance expectations for each peer role.

One important consideration revolves around the types of employment options available for peer/recovery workers. Agencies should not assume that trained peer workers wish to remain a peer forever or that delivering peer services is the employment goal of each individual. Ideally organizations will define a range of employment opportunities from which peer workers can select based on available openings, interests and skills.

Other structural issues to consider include:

- A clear understanding of how peer staff are integrated into the agency's overall operations. What is their role in service delivery?
- Agency guidelines for recruiting peer/recovery specialists
- Competitive wage policies
- Methods to maintain supervisor and staff enthusiasm, including employee forums for resolving issues and brainstorming solutions
- Materials and staff members identified for training peer/recovery specialists or access to training programs that other agencies provide
- Training for supervisors and other staff on recovery, the role of peer employees, staff team-building and other good employment practices
- Provision of consistent supervisory standards that are compatible with job expectations
- Reviewing human resource policies on dual relationships and reasonable accommodations, including unpaid leave with flexibility to re-enter a job and providing routine information on linkages to community-based wellness resources for all staff
- Opportunities for advancement and career ladders
- Equal access to all benefits including employee assistance programs.

Culture, Age, Gender

Outcomes research on "matching" peer worker staff to service recipients is limited. However, agencies should assume a practical point of view with regard to the target population to be served and the nature of the services to be delivered when considering a possible peer-recipient match just as they do with traditional staff. If knowledge of the unique cultural practices and preferences of an individual is important for successful

engagement, retention and satisfaction of a person with their behavioral health services, then culture should be a strong variable for consideration in assigning a peer/recovery worker. Similarly, age and gender-specific selections should be considered based on the unique situation of the person and his/her preferences (e.g. women involved with CPS, individuals who have experienced homelessness or criminal justice involvement). With strong clinical supervision models in place, mixed-gender pairings are also successful. In these situations the organization may also need to consider any trauma background for both the workforce and the service recipient.

Employment/Hiring Considerations

An initial challenge for agencies is to identify and recruit the first group of peer/recovery specialists. In the initial recruiting phase, organizations should consider the following general guidelines:

- The initial group of peers is very important, as they will be pioneers for new services and serve as role models. Seeking individuals who are enthusiastic, excited and have strong "people skills" is critical to building the new workforce.
- Where the available position is that of a peer/recovery support worker, recruiting peers who have a strong knowledge of key recovery concepts.
- Referrals from training agencies and recommendations from other peer workers can become a primary method for recruiting peers.
- Begin by hiring several peer workers (at a minimum two) to provide support to each other, avoid isolation, and build the program
- Clarify the job status and roles of peer employees – full-time, part time, or *ad hoc.* A mix of options that can be tailored to the interests and preferences of the individual is preferred.
- As with any position, matching the abilities of the persons with the organizations needs is essential. Identifying clearly the organization's needs including key responsibilities and job duties is beneficial to both the employee and the employer. A well defined job description will outline expectations and assist the employee in their performance and also help the employer in the selection of candidates who have matching abilities and skills.

Agencies should identify criteria upon which recruiting decisions are made. For instance, initial basic criteria could include the following:

- Needs and goals of the organization
- Interest in and commitment to training to become a peer/recovery specialist and providing peer/recovery support services
- Ability to perform the job tasks
- A desirable combination of peer/recovery characteristics (e.g. enthusiasm, interpersonal and other skills, commitment, integrity, knowledge, attitudes, and leadership capabilities)
- Knowledge of recovery tools and resources in the local community
- Ability to pass state fingerprint requirements where these apply
- Agency parameters regarding self disclosure

Peer/recovery specialists work under the same standards as any other employee. When any candidate for any position has a qualifying disability, then the ADA guidelines about interview questions must be observed. Agency procedures for reasonable accommodations must be followed.

Negotiating Peer and Non-Peer Staff Relationships

Non-peer staff in the past has voiced concerns about "dual relationship" issues, especially when the peer worker is employed at a site in which they receive services. Whether this becomes a situation that needs special attention will be determined by the role the peer worker has in the workplace. The role of the peer worker should be evaluated to determine whether a conflict or "dual relationship" exists. For example a peer worker

should not be expected to work directly with or for a counselor they are also seeing for services. Alternate roles that do not place the peer worker in an employee relationship with their own service staff can easily be designed, such as facilitating WRAP or Wellness classes for other individuals served at the agency. Job assignments and roles can be adjusted to working in an area that would minimize issues related to "dual relationships".

It is not useful to create inflexible rules about who can work where, since this may impose an unnecessary barrier to employment for the peer worker. However, employers should consider the role for which the peer is being hired, how the peer will interact with non-peer staff, and whether professional boundaries can be successfully negotiated. Non-peer staff can do this on their own or they can work with their Human Resources department to ease the transition of peer workers into the workplace. Often these issues can be avoided simply by educating both the peer worker(s) and non-peer worker(s) about specific concerns and provide training to all staff on the roles and expectations for all employees and volunteers. In addition, the agency should begin training before peer staff are introduced into the agency, and continue addressing agency relationships as part of an ongoing training program.

Distinguishing Roles and Establishing Professional Boundaries

All programs should be aware of the potential for role confusion for peer staff in transitioning from the role of the service recipient to the role of a service provider, as well as understanding how to maintain professional boundaries in the context of providing services. Such transitions are eased by providing specific training on professional boundaries that clearly distinguishes the role of service provider and service recipient. All staff who have contact with service recipients can benefit from participation in these training programs. Training should establish clear guidelines regarding agency expectations for maintaining professional boundaries and provide a variety of examples of both appropriate and inappropriate behavior, including consequences for conduct violations. Essential concepts include:

- Peer staff – like any other employee – should never become involved in a personal relationship (e.g. dating) with a person to whom they are providing services. This restriction extends to "off" hours as well.
- Staff should never borrow money from service recipients and they have a duty to protect the privacy rights of service recipients.
- Clarifications that these protections also extend to persons to whom peer staff provided services to in the past.

Agencies must establish clear expectations so that all staff know what kind of behavior is unacceptable and that violations of conduct standards are taken seriously and could result in termination. Many organizations and agencies have established a Code of Ethics that can provide assistance in the development of protocols, policies, trainings, and supervision. Below is an example of the Code of Ethics established for Psychiatric Rehabilitation Practitioners which offers a useful model for agencies seeking to adapt their risk management policies to accommodate a peer workforce.

The Code of Ethics for Psychiatric Rehabilitation Practitioners Services adopted by the International Association of Psychosocial Rehabilitation Services (IAPSRS) Board of Directors on May 7, 2001 offers a guide for conduct which includes but is not limited to the following:

1. When Practitioners experience personal problems that may impair their performance, they will seek guidance and/or refrain from professional activities that may be affected.
2. Practitioners are to be alert and resist the influences and pressures that interfere with their professional performance.

3. Practitioners are continually cognizant of their own needs, values and of their potential influential position, in relationship to persons receiving services. Practitioners do not exploit the trust of persons receiving service.
4. Practitioners do not exploit professional relationships for personal gain (or benefit).
5. Practitioners do not intimidate, threaten, harass, use undue influence or make unwarranted promises of benefits to persons receiving services.
6. Practitioners do not practice, condone, facilitate or collaborate with any form of discrimination on the basis of ethnicity, race, color, sex, sexual orientation, age, religion, national origin, marital status, political belief, mental or physical disability, or any other preference of personal characteristic, condition or state.
7. Practitioners avoid relationships or commitments that conflict with the interests of persons receiving services, impair professional judgment or create risk of harm to persons receiving services, including, but not limited to, financial, business and familial, social or close personal friendships. When dual relationships are unavoidable, it is the responsibility of the practitioner to conduct himself/herself in a way that does not jeopardize the integrity of the helping relationship.
8. Practitioners under no circumstances engage in sexual activities with individuals to whom they are providing services.
9. Practitioners do not provide direct services to individuals with whom they have previously had an intimate relationship.
10. Upon the conclusion of the helping relationship, it is the practitioner's responsibility not to enter any relationship with the person formerly receiving services that could be detrimental to that person.

As with all staff, appropriate training, ongoing monitoring of performance and supervision is essential. Agencies need to have established written protocols to respond to allegations of staff misconduct, including considerations for any immediate actions necessary to protect the safety and well being of both the service recipient and peer staff. Written policies help ensure that all employees know the "rules". Protocols should include the procedures and timeframes for investigating and identifying any actions necessary. In addition, agencies should be prepared to offer support and assistance to all those involved in an investigation.

Job descriptions

Job descriptions for peer/recovery specialists, like those for all employees, should reflect the tasks of assignment and the value of the service. The more job descriptions reflect organizational values, the more effective they will be in highlighting the uniqueness of each position.

Competitive Pay

Salaries are set in ranges that reflect the value of the services. Peer services have proven to be a valuable addition to the behavioral health workforce.

Employee Benefits

Peers should have access to all benefits provided for employees of the agency, including EAP. Depending on the employment history, skills and experience of the individual, peer employees may need additional information on how to access and utilize all available employee benefits.

Encountering/Reimbursement

Peer-delivered services may be provided to both enrolled service recipients and non-enrolled service recipients consist with the agencies contract and program description. Below is a general description of potential funding for peer-delivered services:

- *Enrolled Service Recipients*
  In Arizona's behavioral health system, peer-delivered services can be reimbursed through a variety of funding streams and can touch both enrolled and non-enrolled populations. In order to receive reimbursement through the state's Medicaid program (AHCCCS), Peer/Recovery Support services must be delivered to enrolled members to assist them in achieving specific treatment and recovery goals as identified on their service plan. Such services are distinct from mutual aid or "self-help" support groups such as Recovery, Inc., Alcoholics Anonymous and Double Trouble groups, which are valuable natural supports for recovery and community linkage, but do not require a professional referral or treatment plan.

- *Non-Enrolled Service Recipients*
  Outreach services to non-enrolled individuals may be reimbursed through the use of administrative funds, community reinvestment funds or with approved grant funds.

Billing for Services

Peer workers may bill an array of the ADHS/DBHS Covered Behavioral Health Services, depending on the services that the person or agency is qualified to provide, the service standards and billing limitations. For example a Peer Worker may provide:

- *Support Services*- such as Self-Help/Peer Services as an employee of a Community Service Agency or a licensed behavioral health agency.
- *Rehabilitation Services*-such as Skills Training and Development if the individual qualifies as a *behavioral health professional*, *behavioral health technician* or *behavioral health para-professional* as defined in A.A.C. R9-20 and is licensed or an employee of Community Service Agency or licensed behavioral health agency.
- *Treatment Services*-such as Individual Behavioral Health Counseling and Therapy depending on whether the Peer worker is an independent practitioner, behavioral health professional or behavioral health technician as defined in A.A.C. Title 9, Chapter 20 and the type of the provider agency in which the person is employed.

Please refer to the ADHS/DBHS Covered Behavioral Health Service Guide at http://www.azdhs.gov/bhs/bhs_gde.pdf for specific service definitions and descriptions including identification of specific provider qualifications/service standards and limitations.

Training

Employment programs for peer workers are most successful if preceded by comprehensive training on recovery principles and practices. Training provides an opportunity for individuals to move from their own recovery to assisting others in the process. Without this prerequisite, the task of successfully employing peers and maximizing the value of their contribution may be fraught with misunderstanding and unnecessary performance challenges. There are several quality peer-training programs available in the State of Arizona. It is recommended that graduates from these programs be considered preferred candidates for positions as they are well trained in recovery and peer support practices. Agencies should also consider the availability of advanced training tracks, including team building and leadership development that may be provided jointly for all agency staff.

Peer workers should attend the same new hire orientation training as any other employee performing similar duties including service documentation procedures and developing progress notes.

Supervision

Supervision is one of the most critical aspects of a successful peer worker program. Oversight and supervision is most effective when utilizing a "coaching" philosophy for all employees instead of a traditional "supervising"

approach. Coaching mirrors more of the recovery attitude and approach that peers are expected to personify in their work with others who are receiving behavioral health services. Coaching in a group process combined with individual coaching has been found to be most effective. Group coaching promotes the commonality of purpose and experience while increasing the comfort level with the group process. Individual coaching allows for clarification and strength identification. Coaching reinforces the value of "person-directed" recovery. In this approach, the peer employee "owns" their own performance improvement in a partnership with the coach, which leads to better outcomes. Preferably, the coach is also a peer, although this is not a requirement. Agencies are encouraged to develop a career ladder that allows for this type of peer-to-peer supervision which, in the long run improves staff longevity and provides for promotional opportunities.

The experience of programs employing peers demonstrate that the more inclusive the program is, with peers as equals on the team within their unique function and role, the more successful the entire team. Supervision (coaching) and training of all team members in a parallel manner should ensure that the team stands shoulder to shoulder and shares in the mission of the program.

Supervision standards for peer workers vary depending on the education, experience, certification or licensing requirements of the employee. Additional information on current Arizona requirements can be obtained at:

1. Arizona Administrative Code – Title 9, Chapter 20, Section 205 Clinical Supervision http://www.azsos.gov/public_services/Title_09/9-20.htm
2. Arizona Board of Behavioral Health Examiners, http://www.bbhe.state.az.us/.

For example, the Arizona Administrative Code, Title 9 Chapter 20, Section 205 D. indicates that a licensee shall ensure that:

1. A behavioral health technician or a behavioral health paraprofessional who works full time receives at least four hours of clinical supervision in a calendar month;
2. A behavioral health technician or a behavioral health paraprofessional who works part time receives at least one hour of clinical supervision for every 40 hours worked; and
3. Clinical supervision occurs on an individual or group basis and may include clinical supervision in response to an incident, an emergency safety response, or, if applicable, debriefings that occur after restraint or seclusion.

A final consideration on supervision practices: Employers and supervisors need to recognize the difference between the agency's obligation to provide supervision and the need for an employee to receive vocational or behavioral health services. Drawing a clear line to separate the agency's "supervision" requirements and any consideration of a staff member's need for "treatment" is imperative to successful implementation of a peer worker program. Supervisors need to recognize the need to encourage all employees, not just peer workers, to utilize employee assistance programs and other benefits offered by the agency. However, it is not the supervisor's role or responsibility to monitor or recommend that the employee participate in behavioral health or vocational services.

Anticipated Outcomes

Individual

Increased confidence, competence and self-efficacy
Opportunity to enter the behavioral health workforce, gain experience and prospect of future career advancements in the field

Agency

Improved employment outcomes
Reduced inpatient utilization

Increased satisfaction among service recipients and staff
Establishes an entry point and potential career ladder to increase workforce

System
Reduced stigma, discrimination and prejudice
Improved engagement
Reduced no-shows for appointments

❖ Key elements to remember about this best practice:

A growing body of scientific evidence supports the development of the role of peer/recovery support staff as a unique way to foster empowerment and hope. The role of peer/recovery support staff is flexible and varied. Behavioral Health Agencies seeking to develop a peer workforce should invest sufficient time and attention to planning early in the process. This protocol provides guidance regarding key components of a successful peer program that includes, but not limited to:

- Assessment of agency values, beliefs, and structure that supports a peer workforce
- Employment/hiring considerations
- Negotiating peer & non-peer staff relationship
- Distinguishing roles & establishing professional boundaries
- Training and Supervision
- Encountering/billing for peer support services

Role of the of the Peer/Recovery Specialist

Common roles for peer employees in agency settings include providing education "about treatment," engaging family and friends in building a Adult Clinical/Recovery Team and linking the individual to natural supports within the community. Some peer/recovery specialists work independently, visiting people in their homes or at other locations in the community. Peers may also provide a range of specific educational and coaching services, including WRAP and Wellness Planning, skills training, preparation for GED or other career paths, work supports and job/role modeling and even training to work as a peer/recovery specialist. Agencies with a unique cultural orientation to behavioral health treatment have successfully used peer employees to assist individuals in re-discovering their culture and heritage as a means of building recovery capital within their lives.

In addition to providing services in agencies licensed or certified by the ADHS Office of Behavioral Health Licensure (e.g. outpatient clinics, residential agencies, inpatient treatment programs) many employment opportunities exist in peer or consumer-operated programs (e.g. recovery centers/drop-in programs) certified as a CSA.

In Arizona, the minimum staffing requirement for peer-delivered services within licensed behavioral health agencies is the behavioral health paraprofessional as defined in R9-20-101 and R9-20-204. Peer workers that meet the requirement to function as a paraprofessional may work in any role for which they are qualified within the organization. Peer employees hired by a certified Community Service Agency (CSA) must also meet minimum staffing requirements for paraprofessionals as defined in R9-20-101 and R9-20-204 to deliver support services identified on a treatment plan

Training

Employment programs for peer workers are most successful if preceded by comprehensive training on recovery principles and practices. Training provides an opportunity for individuals to "connect the dots" from their own recovery to assisting others in the process. Without this prerequisite, the task of successfully employing peers and maximizing the value of their contribution will be fraught with misunderstanding and unnecessary performance challenges. Agencies should also consider the availability of advanced training tracks, including team building and leadership development that may be provided jointly for all agency staff. Peer workers should attend the same new hire orientation training as any other employee performing similar duties including service documentation procedures and developing progress notes.

Supervision

Supervision standards for peer workers vary depending on the education, experience, certification or licensing requirements of the employee. Additional information on current Arizona requirements can be obtained at:

1. Arizona Administrative Code – Title 9, Chapter 20, Section 205 Clinical Supervision http://www.azsos.gov/public_services/Title_09/9-20.htm
2. Arizona Board of Behavioral Health Examiners, http://www.bbhe.state.az.us/.

Oversight and supervision is most effective when utilizing a "coaching" philosophy for all employees, not only peer employees, instead of a traditional "supervising" approach. Coaching mirrors more of the recovery attitude and

approach that peers are expected to personify in their work with others who are receiving behavioral health services. Coaching in a group process combined with individual coaching has been found to be most effective.

- Benefits of using this best practice:
  - Use of this protocol will provide guidance to Behavioral Health Agencies in implementing peer/recovery support services
  - Will enhance the effectiveness of mental health and substance use disorder treatment through the expansion of peer-delivered services
  - Will clarify the role of the peer/recovery specialist in Behavioral Health settings and provide for service expectations to enhance service delivery